

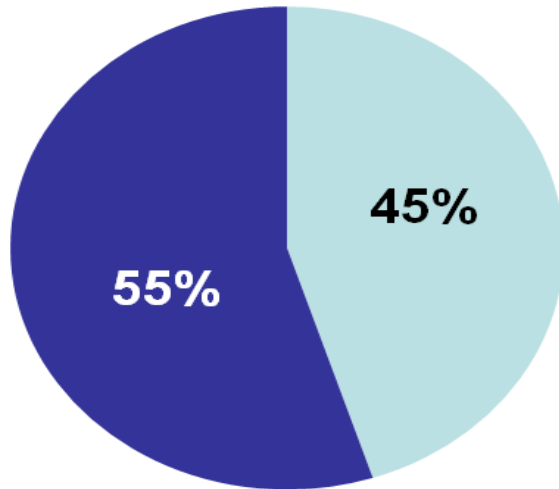


Columbus Regional Health
Diabetes Educators designing programs using Health
Coach extenders in the PCMH.

Objectives:

- Define what generated the **need** for the project.
- Discuss the **delivery design** model in the community.
- Review project **aims**, expected **benefits**, and **barriers**.
- Identify **key deliverables** of the health coaching project.

How bad is the chronic disease crisis?



Nearly **half** of all Americans suffer from at least one chronic condition...



133 million people

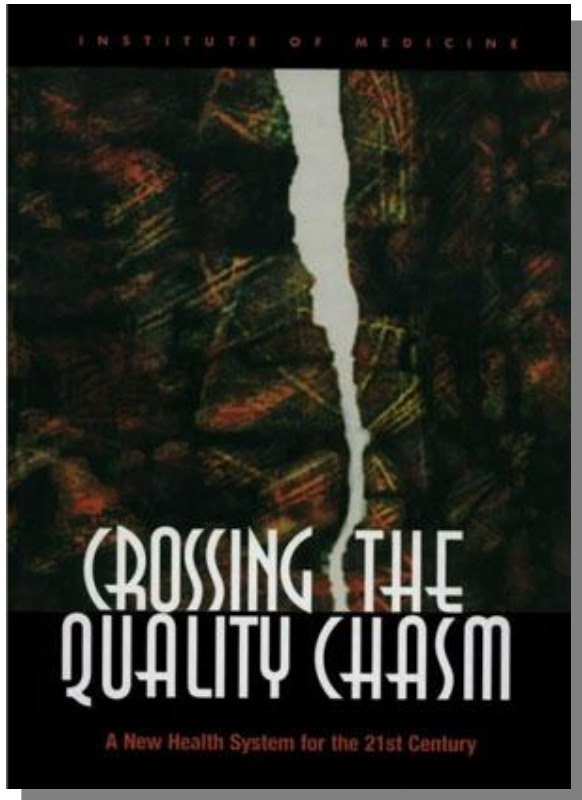


...**75 cents** of each dollar spent on health care goes to treat patients with chronic disease



\$1.7 trillion

The IOM Quality report: *A New Health System for the 21st Century*



“The current care systems **cannot** do the job.”

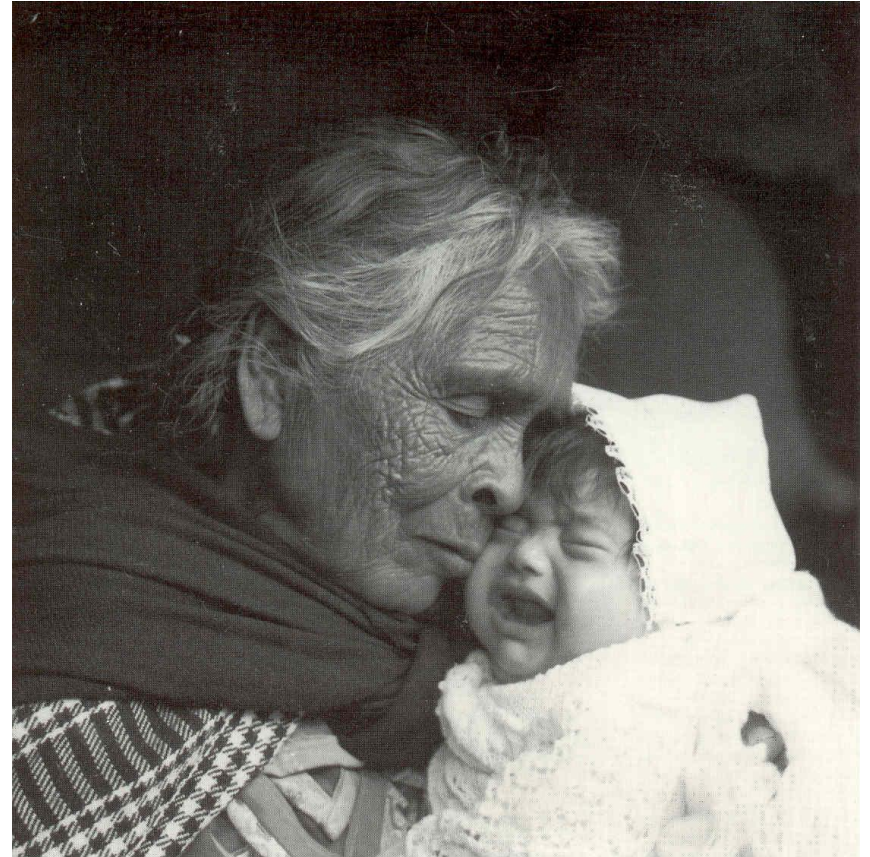
“Trying harder will not work.”

“Changing care systems will.”

<http://www4.nas.edu/onpi/webextra.nsf/web/chasm?OpenDocument>

What People with Chronic Conditions Need- (IOM)

- A “continuous healing relationship”
- Regular assessments of how they are doing
- Effective clinical management
- Information and ongoing support for self-management
- Shared care plan
- Active, sustained follow-up



Chronic Care Model



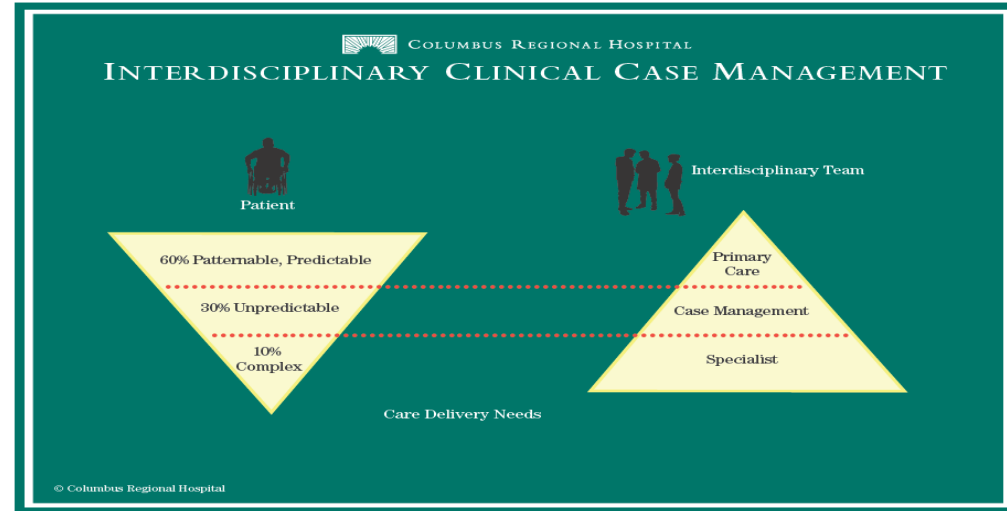
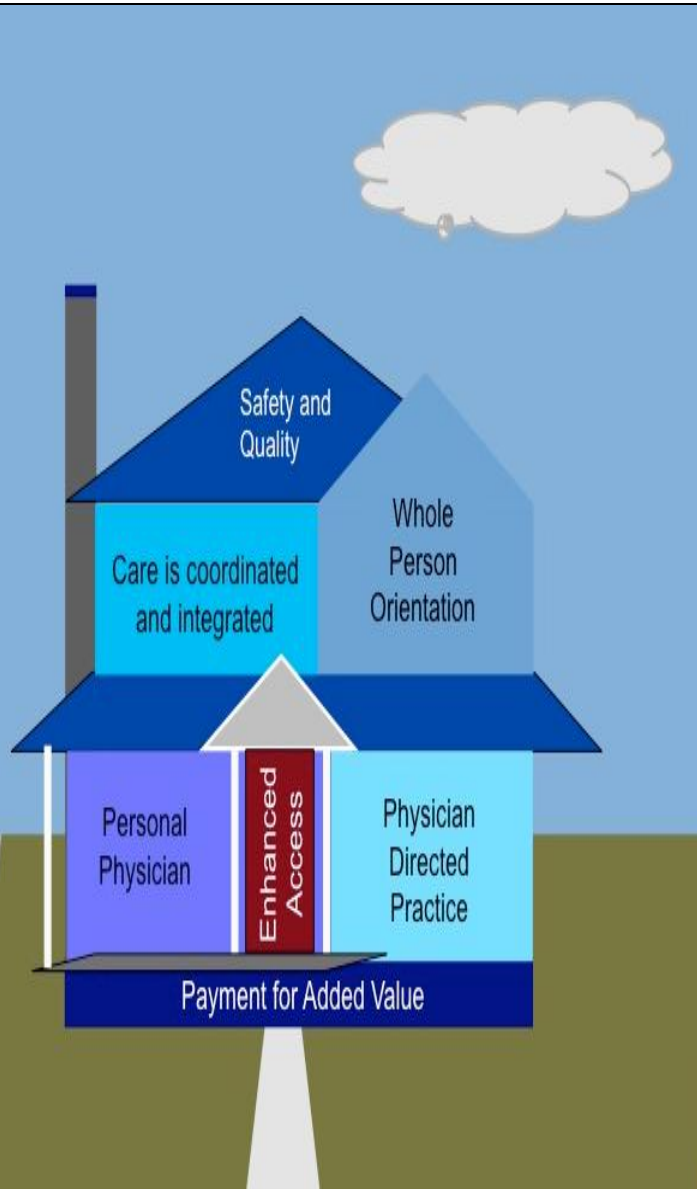
Self-Management Support

- Emphasize the patient's central role.
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up.
- Organize resources to provide support.

Delivery System Design

- Define roles and distribute tasks among team members.
- Use planned interactions to support evidence-based care.
- Provide clinical case management services for high risk patients.
- Ensure regular follow-up.
- Give care that patients understand and that fits their culture.

Care Delivery Models in Community



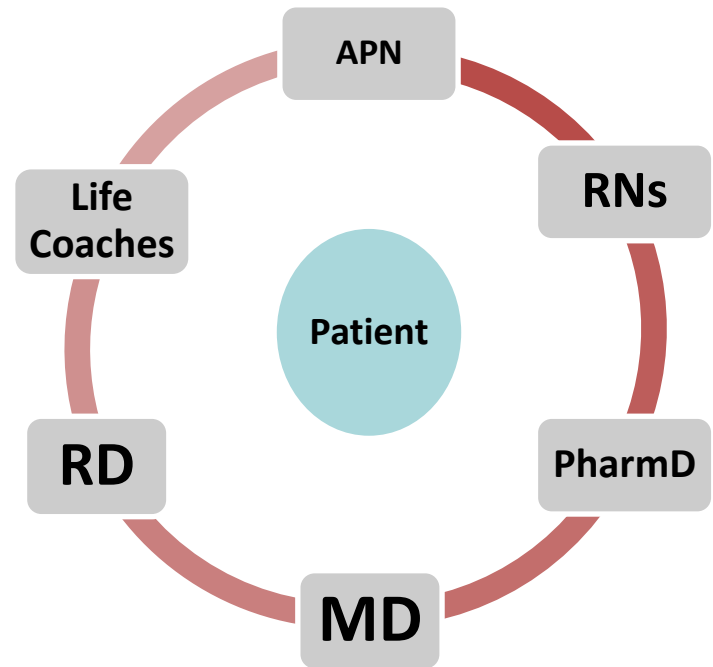
Diabetes in our Community

- 13% of adults in a three-county service area (Bartholomew, Jackson, and Jennings) have diabetes; 11% of adults in Bartholomew County have diabetes; and 28% of adults who are 65 and older have diabetes.
- Among the adults with diabetes, 86% are currently taking insulin or some type of medication to manage their condition.
- 5% of the population with diabetes in Bartholomew County accessed diabetes information from the CRH DSMT accredited program- only 10% uninsured VIM patients accessed DSME services despite a no fee for service referral.
- No competing educational programs in community or educators in the office setting

According to the 2012 Community Health Survey

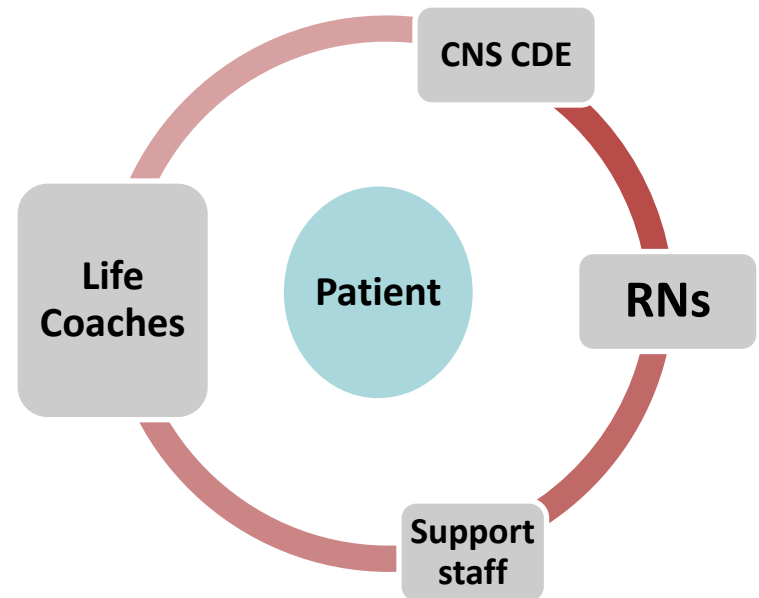
Volunteers in Medicine

- VIM model designed without regard to reimbursement
 - Access
 - Incentive
 - Make wait time productive
 - Monthly Chronic Disease Mgt Clinics



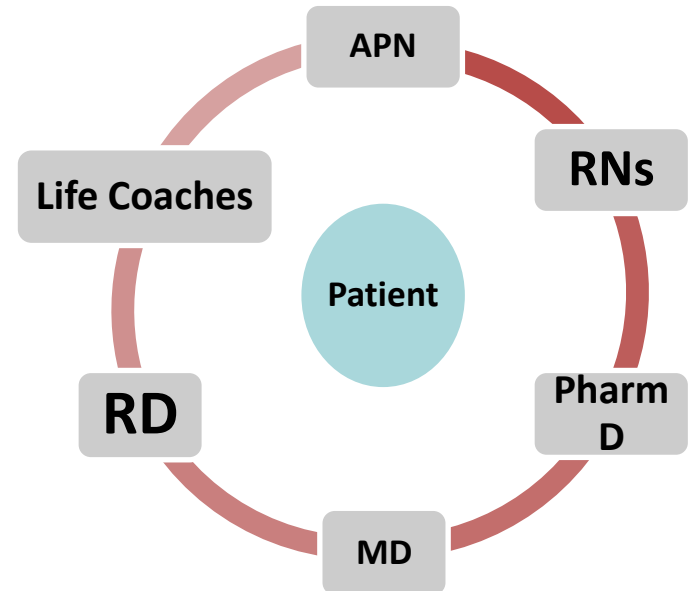
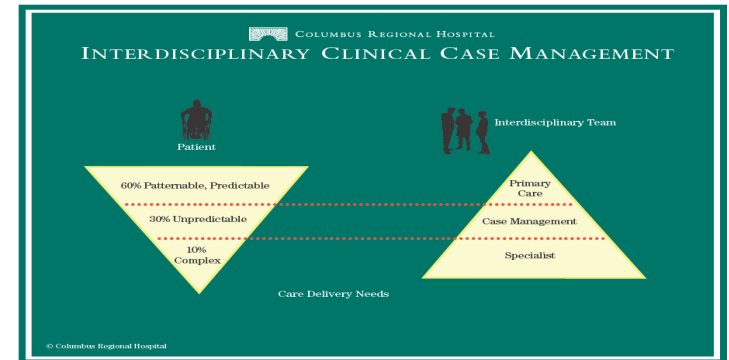
Volunteers in Medicine

- Spanish speaking Chronic Care clinic for on going group and 1:1 education and support.



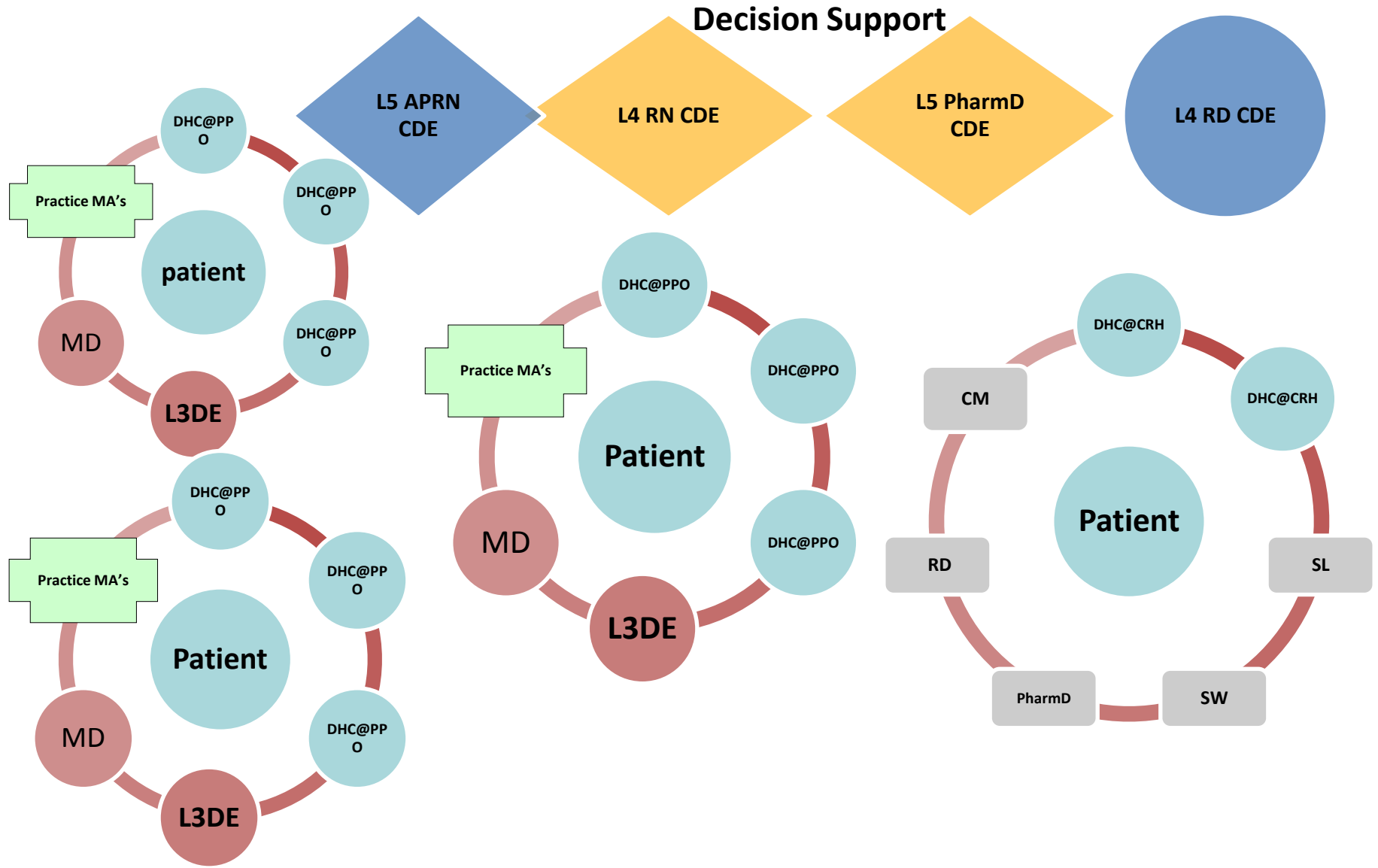
Our Community Story- Connecting the Dots

- The AADE accredited outpatient diabetes program at CRH applied lessons learned from work at Volunteers in Medicine to the delivery design.



An integrated chronic care delivery design model

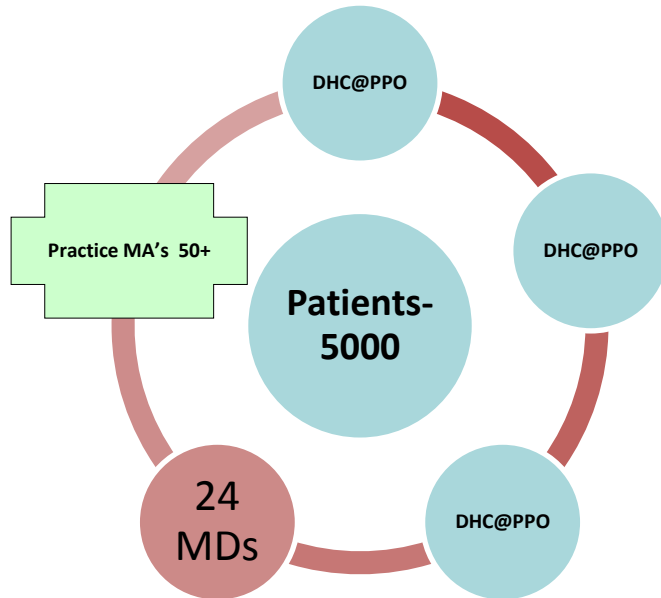
was envisioned for the community. (Applied for CMS grant 2012)



Funding

- Columbus Regional Health Foundation
“venture philanthropy to accelerate innovation in healthcare delivery”
- American Association for Diabetes Educators-
Education and Research Foundation
 - ***Reaching Out for Better Health: A Community-based Diabetes Education Program***

Decision Support



- The AIM of the Health Coaching Project is to improve healthcare, health outcomes, and reduce costs for adults with diabetes.
- Aims are consistent with CMS measures and CRH Diabetes Outpatient Services and the strategies align with NCQA's PCMH/N goals .

American Association of Diabetes Educators

- **3** coaches hired, trained, and deployed to **6** primary care practices representing **24** physicians in the community.
- The Physician Director over the PCMH championed the project to engage the providers from the onset.
- Coaches had intense **3** week training led primarily by the core group of multidisciplined CDEs, supplemented by key community providers and members.
- AADE primary resource for program design elements-competencies, policies, curriculum

Coach Training

- AADE7
- SMART goal setting
- Motivational Interviewing
- Resource utilization and navigation specific to the community
- Completion of AADE L1 certificate path
- The on-going link and partnership between coach, CDE and other expert resources in sustaining program viability and capacity is key priority.

Our Community Story- Connecting the Dots

- The goals for:
 - Diabetes Health Coaching Project /CRH Diabetes Services
 - AADE Reaching out for Better Health grant ,
 - CDM program at Volunteers in Medicine (Healthy Communities Initiative)
 - PCMH/N initiative
 - Chronic Care focus of CRH's Innovation Center

Intersect and align all the bodies of work and generated **“need” and momentum** for the project work in the community.

Aims for Health Coach Project

- **Healthcare**-Improved access to diabetes and chronic care education / support
- **Health Outcomes** -Aggregate behavioral goal measurement around A1c 7 with improved A1c measures
- **Outcome (cost strategies):**
 - Quantify indirect cost savings through relative risk reduction with drop in A1c and self report measurement hospital / ED use;
 - Improve relative risk reduction scores with A1c reduction-measure indirect cost associated with chronic complications of diabetes to include: CVD, blindness, renal disease, and amputations

Key deliverables

- **Enhanced Workforce - Coach Development**
- **IT -EMR Development**
- **Integrated Care Delivery Model –**
 - Effective use of expert resources – Layering the working team- coach partners with CDEs to influence more pts – all working at top of license

Key Deliverables

- Improved access/utilization of DSME/S
- Improved physician and patient satisfaction
- Behavior Goal setting with all patients with AADE7
- Improved A1c

Key Deliverables - IT

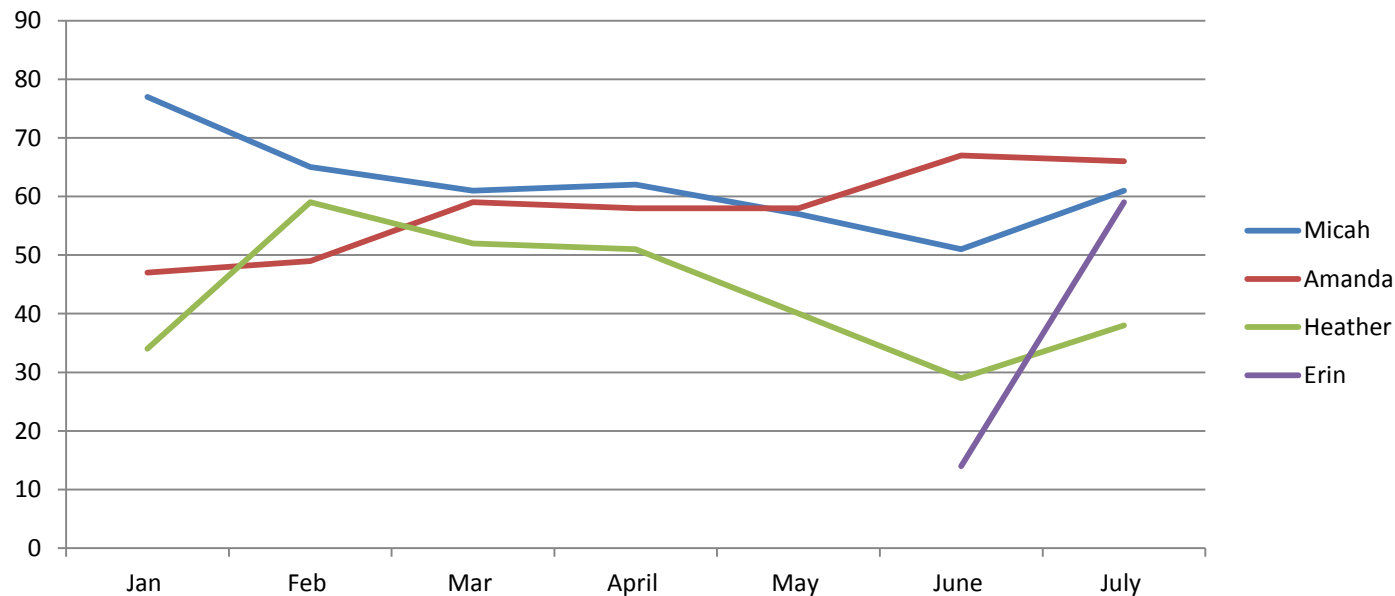
- **Registry** for population management –
 - Fields include initial A1c, current A1c, time in program and A1c difference.
 - Other fields include: last and next appointment date, N of meds, BMI, age, insulin use, and insurance.
 - Registry N for practices as whole = **5383 with diabetes 15% average on insulin**

Key Deliverables - IT

- **Chronic Care Management Tree** in EMR for documentation of education and behavioral goal achievement in alignment with National Standards for Diabetes Education and AADE accreditation. (quality/sustainability)
 - Initial Diabetes Assessment and Follow-up
 - Educator/Coach Progress Form (Goal Achievement)
 - Patient Goals
 - DSME Education Record
 - Flow Sheet

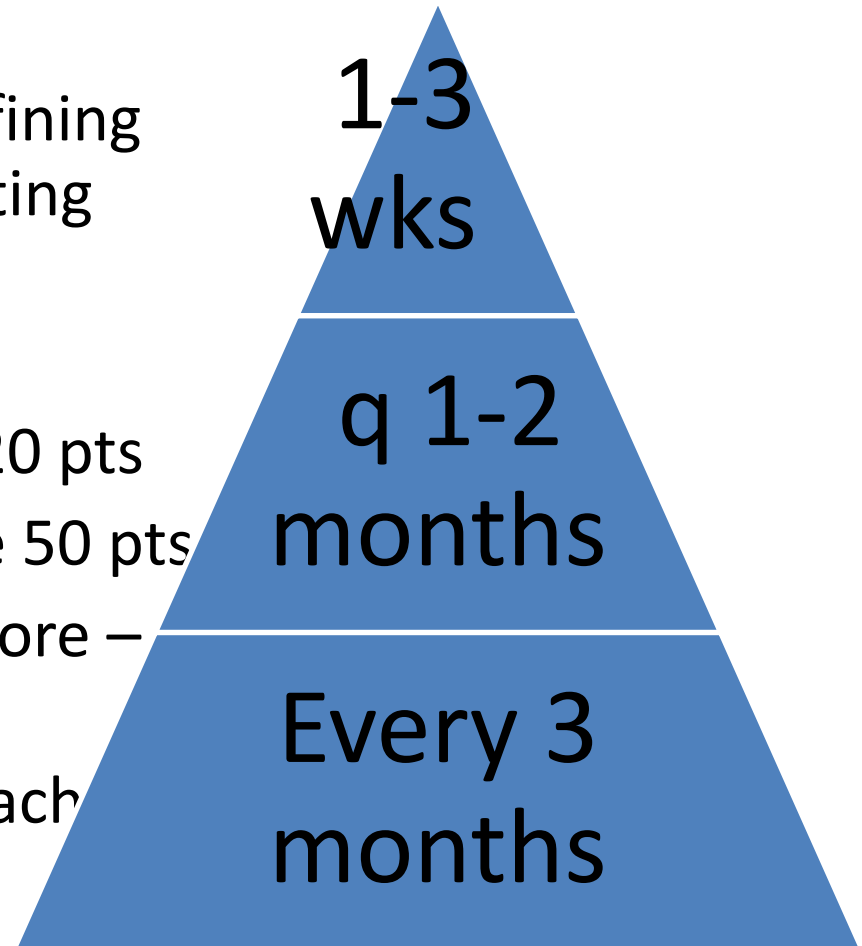
Key Deliverables –Structure and Process

- **3647** encounters June 2012 to June 2013. 1966 (54%) office visits and 1430 (39%) phone connections and 7% email.



DSME/S infrastructure

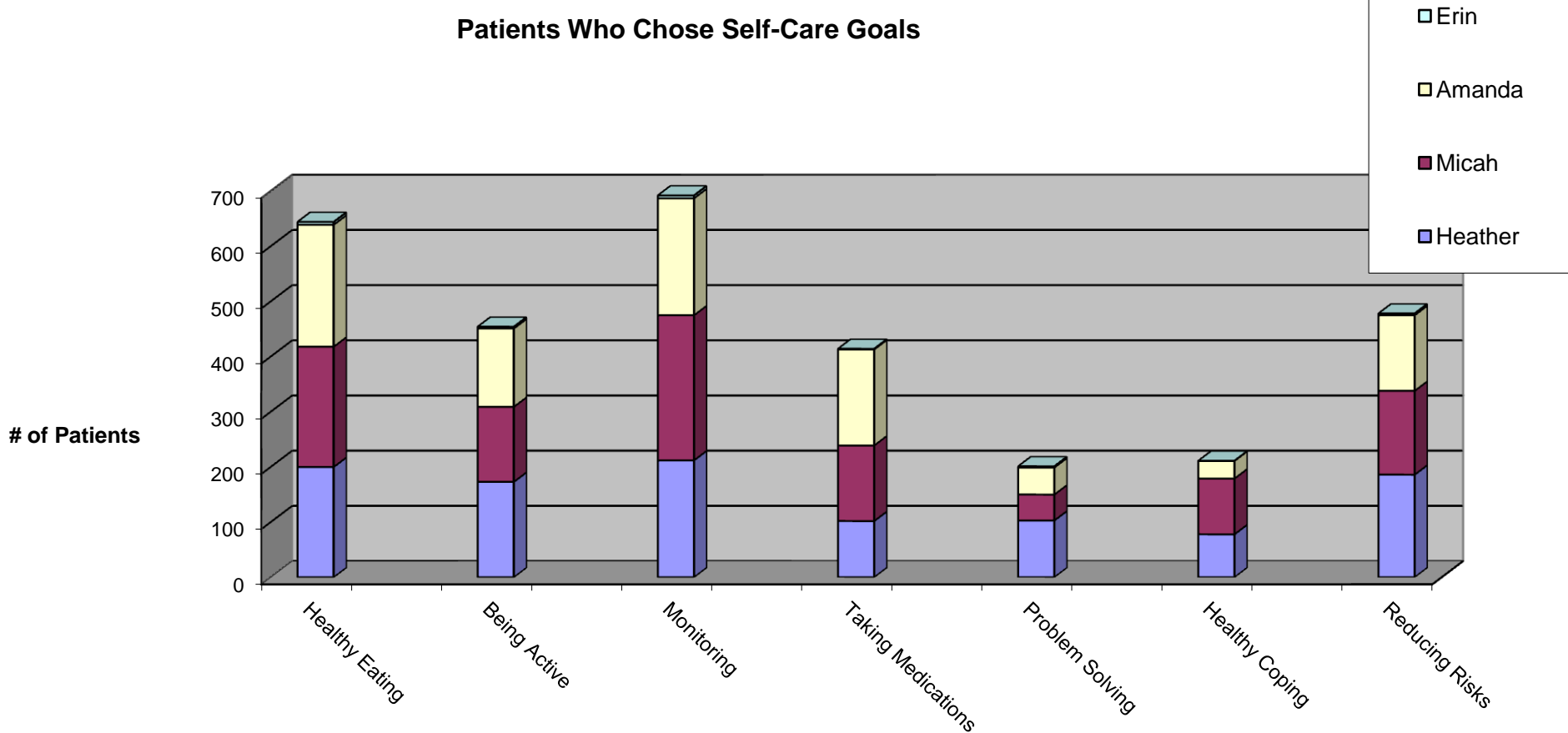
- Program development and population management- refining structure and process—creating capacity.
- Caseload of coaches
- Tier 3 1-3 wks – average 5-20 pts
- Tier 2 1-2 months – average 50 pts
- Tier 1 Every 3 months or more – average over 150
- Averaging 21 new pts per coach month



Aggregate Goal Measurement with % Achievement Across **AADE 7**

- Healthy Eating,
- Being Active,
- Taking Medications,
- Monitoring,
- Problem Solving,
- Healthy Coping,
- Risk Reduction
 - 75-100% on goal achievement scores

Aggregate Goal Measurement



AADE 7 Self Care Behaviors

Increase the proportion of persons with diagnosed diabetes who receive DSME/s

- N =832 individual patients accessed DSME/S in PCMH- (this does not include community SMS numbers or DSME at CRH)
- N=over 250 new skill training at point of care-- injection starts- BGM new starts

Increase Workforce Who Focus on Diabetes

- **4** Health Coaches in primary care offices- (AADE L1 certified)
- **1** VIM /CRH Spanish speaking coach (L1 certified)
- **3** Diabetes Health Coaches in mental health – (L1 certified)
- **3** individuals in training for L1- LPN coach from MD office and 2 independent learners

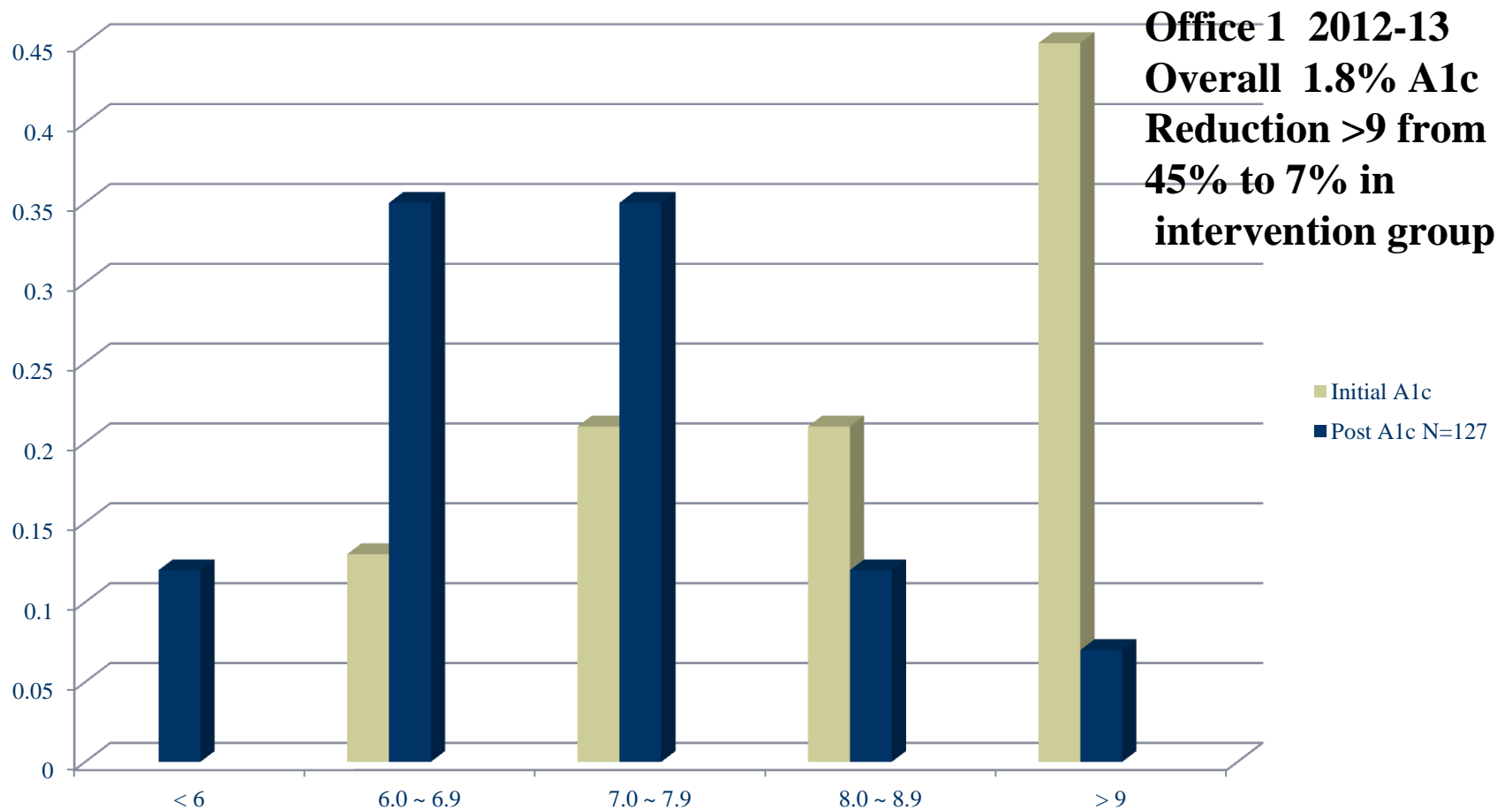
Increase Workforce Who Focus on Diabetes

- Increased proportion of healthcare professional with enhanced diabetes knowledge in the workforce system; focus on MAs in offices, and areas with high volume of diabetes that serve target population / high risk populations
- **38** MAs – **9** individual office programs performed (68 hrs) on diabetes since 06/12

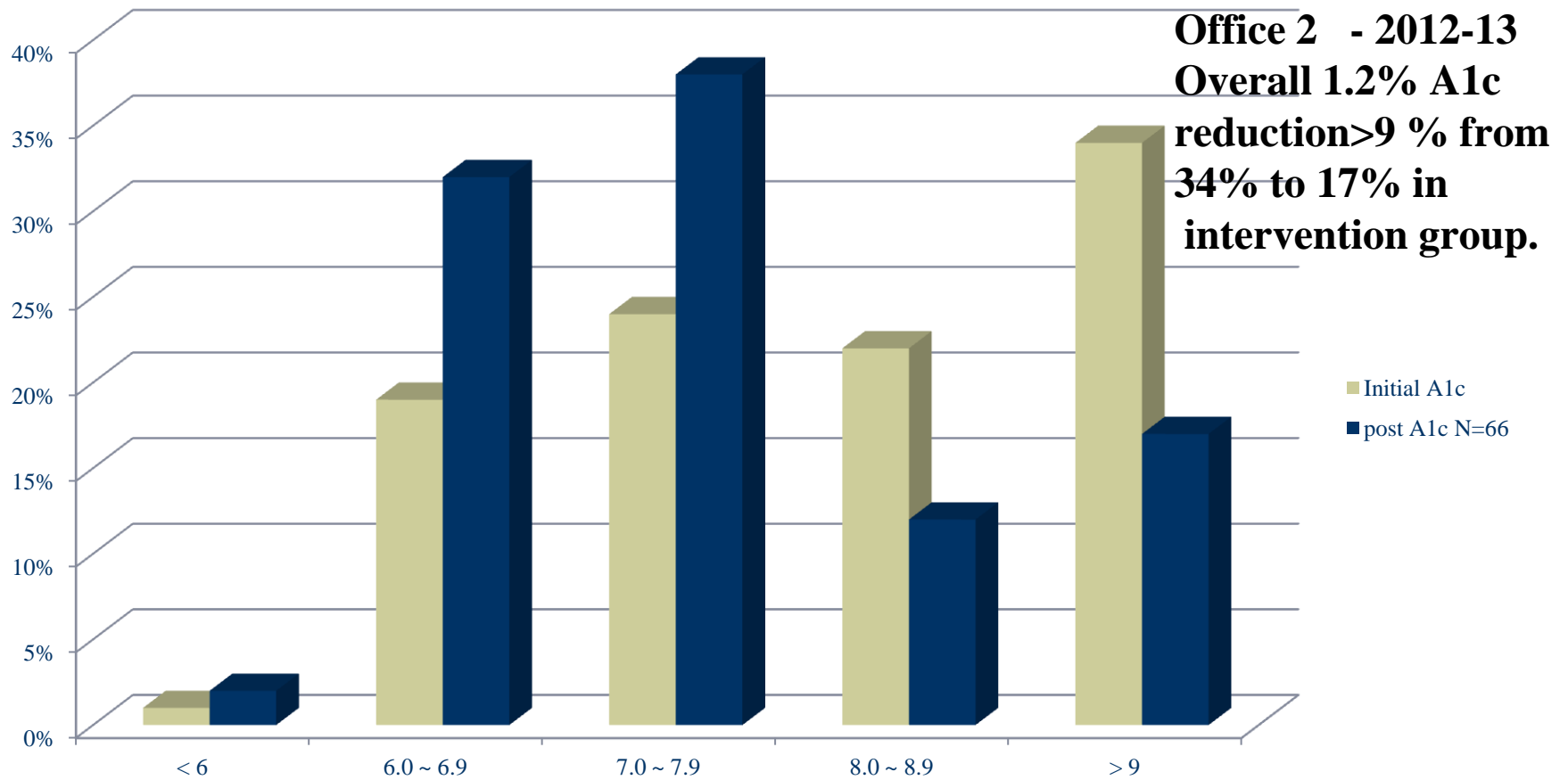
A1c Reduction – Data limitations

- **Limitation of A1c data- exclusions:**
- Coach registry data reveal a significant number of patients needing post A1c measure.
- If a pt had initial A1c but no post A1c measure or in program less than 30 days these data were excluded from data set.
- Average initial A1c for those patients excluded equaled 8.25% for sites combined.

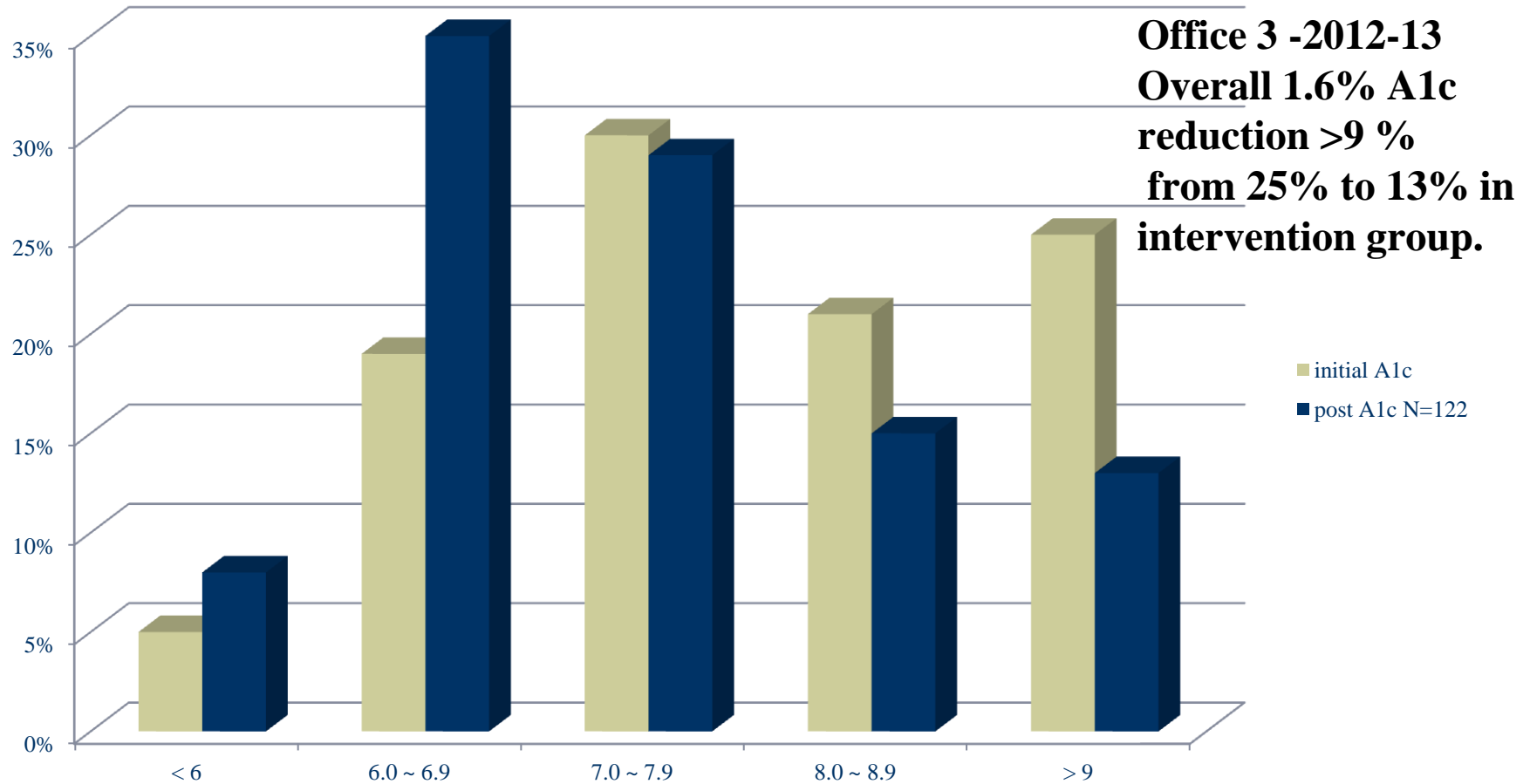
Key Deliverables - Outcomes



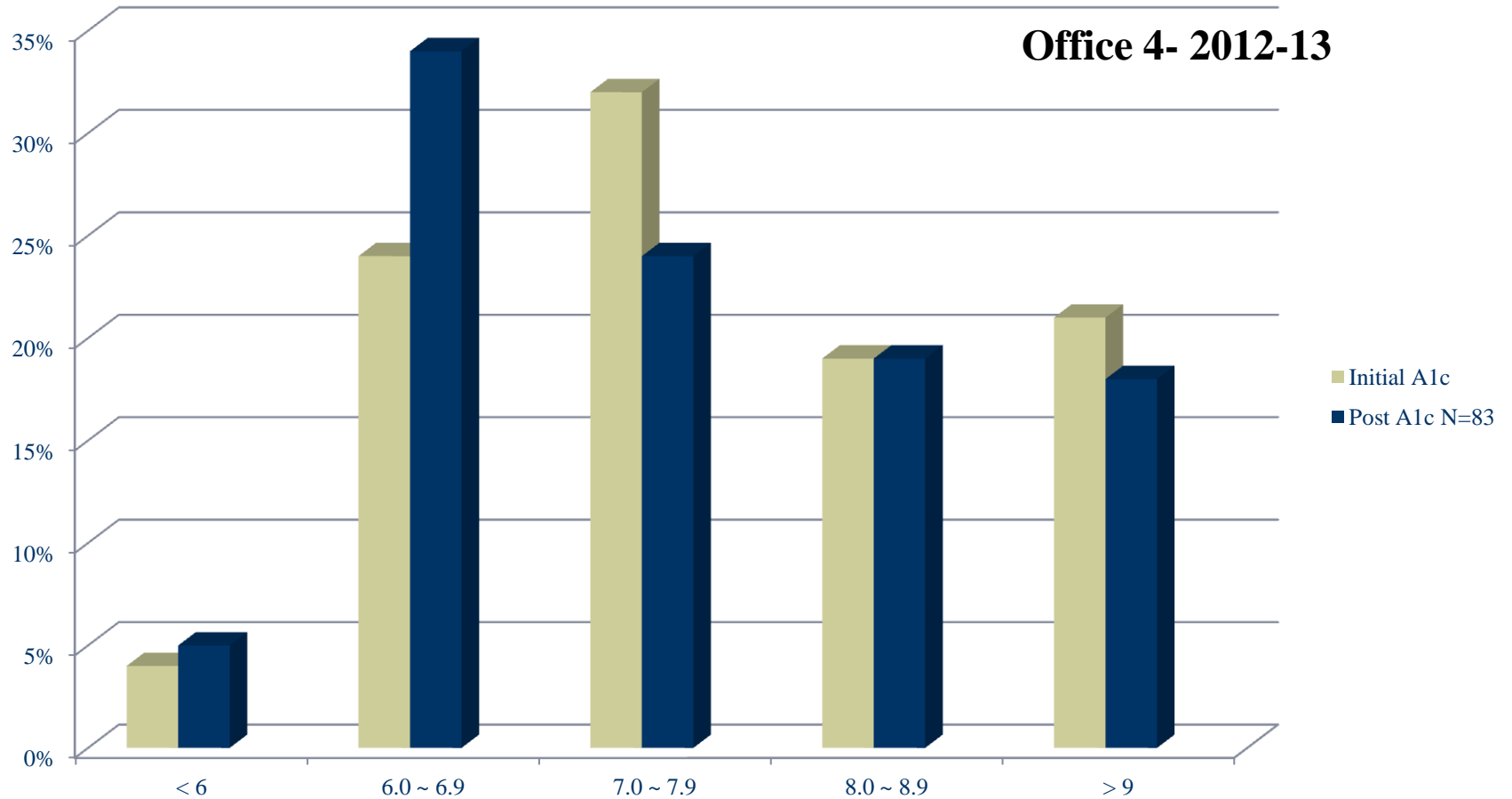
Key Deliverables - Outcomes



Key Deliverables - Outcomes



Key Deliverables - Outcomes



Patient Satisfaction- June 2013

- # of Surveys **44**
- 5=strongly agree 1= strongly disagree
- Coach is courteous and professional. 4.9
- Coach is knowledgeable about diabetes. 4.9
- I understood the information we discussed 4.9
- Time spent in sessions helped me learn new ways to cope with my diabetes. 4.8
- I would recommend coaching to others. 4.9

Patient Satisfaction- June 2013

- My physical activity has increased. **4.2**
- My eating habits have improved. **4.5**
- I monitor my blood sugar more often. **4.6**
- I am better at taking my medication. **4.2**
- My A1C (3 mo average blood sugar) has decreased. **4.2**
- I have lost weight. **4.3**
- I take my medications as directed by my doctor (scaled 1-10) **9.7**
- I have received an eye exam in the last year **77%**
- I have had my feet examined in the last year **68%**

Physician Satisfaction

- Return rate- **79%**
- The coaches communicate effectively with me. **4.5**
- Understanding that the coach plays a supportive, non-clinical role, I think the coach is competent and well-trained. **4.6**
- The coach treats patients and families with dignity, kindness, and respect. **4.9**
- Having the coach in our office has been positive for our patients with diabetes. **4.8**
- I am confident in our coach's ability to help move patient's healthcare metrics through behavior change. **4.6**
- Overall, I am pleased with the diabetes coaching program. **4.7**

Questions?

- Utube video <http://youtu.be/Z0F1ctrHpl>
- Coach Success Stories